

# Quitlines

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## A behavioural intervention success story

In February 2005, the major contributors to quitline development and research met in Washington, DC, at a conference: "Developing a Research Agenda to Improve the Impact of Tobacco Use Quitlines." The five sponsors of the conference—the National Institute on Drug Abuse; Centers for Disease Control and Prevention; National Cancer Institute; the Canadian Tobacco Control Research Institute; and Health Canada—subsequently agreed to support a special issue of *Tobacco Control* on quitlines. We are grateful to these sponsors and to the editorial staff of *Tobacco Control* for making this issue possible. Both the 2005 conference and the special issue testify to the emergence of quitlines as a widely available, evidence based resource for smokers seeking cessation assistance. Anderson and Zhu<sup>1</sup> in the concluding paper of this issue, document the rapid growth and availability of quitline assistance throughout the world.

Our goal was to publish papers that would have value both to the research community and to those making decisions about quitline implementation and funding. The 16 diverse papers in this issue meet this goal. The first paper by Stead *et al*<sup>2</sup> summarises the latest Cochrane Library evaluation of the effectiveness of quitline counselling. Their key meta-analysis is based on 18 000 observations and clearly shows that multiple quitline calls are more effective than a single call or written materials alone. Cummins *et al*<sup>3</sup> describe the range and variation of services offered by quitlines in North America. It is noteworthy that medications are available from many US quitlines, and internet services are often provided in both the United States and Canada. These data were collected under the auspices of the North American Quitline Consortium and this collaboration is also responsible for the development of a minimum data set to be collected by all quitlines as described by Campbell *et al*.<sup>4</sup> The consensual data set together with the huge number of counselling events promises a continued flow of research reports on quitlines.

## STATES AS LABORATORIES

In the United States, most states implement their own quitlines as part of a

comprehensive tobacco control programme. The state health divisions or their quitline contractors routinely perform some level of evaluation, typically sampling quit rates six months or 12 months after the counselling.<sup>3</sup> Quitlines thereby generate a great volume of data and the states—and their health divisions—can use these data to examine many interesting questions. Two papers report on states' experiences in using media advertising to market quitlines.<sup>5,6</sup> The data from these two very different states—New York and Oregon—should be very useful to state health officials. New York has also experimented with offering free services to smokers randomly selected for an epidemiological survey.<sup>7</sup> This study suggests considerable interest in quitline services. Minnesota's tobacco control programme includes several large health plans. Schillo and colleagues<sup>8</sup> describe how their quitline negotiated with these plans in order to share costs and enhance the availability of nicotine replacement therapy. Swartz and colleagues<sup>9</sup> document efforts to expand and then maintain the integrity of Maine's quitline across years in the face of funding vicissitudes.

## QUITLINE COUNSELLING PLUS MEDICATION

Medications such as nicotine replacement therapies (NRT) are known to be effective and over half of the state quitlines in the United States provide free or discounted medication.<sup>3</sup> Quitline sponsors—for example, state health divisions, must allocate scarce resources and a major choice concerns how much to spend on counselling versus medications. Several papers in this issue report on the impact of introducing free NRT on both recruitment and quit rates. Both call volume and quit rates are enhanced when free NRT is made available,<sup>10,11</sup> and NRT appears to be a cost effective means of increasing both call volume and quitting.<sup>11</sup> In a large, factorial design, Hollis *et al* examine the effectiveness of different levels of counselling intensity combined with free NRT.<sup>12</sup> Both nicotine patches and counselling intensity increase quit rates and cost data are also provided to guide quitline managers.

## REACH OF QUITLINE SERVICES

While widely available, quitlines are typically used by only a very small proportion, 1–2%, of smokers,<sup>3</sup> although there is much variability that is related to levels of expenditures.<sup>1</sup> Within a given level of utilisation, there is still the question of whether socioeconomically disadvantaged smokers, or smokers from different ethnic backgrounds, make use of quitline services. Two papers in this issue, one reporting on aboriginal smokers in Canada,<sup>13</sup> and one from the United States,<sup>14</sup> examine this issue. Both report that disadvantaged or ethnic smokers use quitline services at a level similar to the general population and benefit at least as much as do smokers in general.

## PROTOCOL VARIATION; QUITLINE FUNDING; HISTORICAL PERSPECTIVE

Although there is ample evidence that multiple calls are more effective than a single call<sup>2</sup> little empirical attention has been paid to the number or duration of counselling calls. Rabius and colleagues<sup>15</sup> address this issue and find that protocols varying in the number or duration of calls tend to yield similar outcomes. In the United States, state quitlines are funded by different sources and at very different levels. Keller and colleagues<sup>16</sup> investigated whether state characteristics predicted the presence of a quitline—and the level of funding. Cigarette excise tax rate predicted the presence of a quitline, and high rates of cigarette consumption and higher expenditure for tobacco control programmes predicted the level of quitline funding.

In the concluding paper, investigators from the first state quitline, California, review the history of quitline development and suggest future needs and directions. Their recommendations include the development of benchmarks for key features of quitline implementation, and research on the utility of combining quitline counselling with medications and with web based programmes.

The papers in this issue, as well as previous research, show that quitline counselling is effective, cost effective, has been widely adopted and can be augmented by evidence based medications. The nature of quitline services makes them highly amenable to research: standardised protocols and data collection; contractually required and feasible outcome assessments; huge numbers of counselling events. These circumstances guarantee an ongoing stream of empirical research and history strongly suggests that research findings will influence quitline practices.

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